PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		15G675	B. WING		09/07/2011		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER						
PASSAGES INC			990 E HANNA ST COLUMBIA CITY, IN46725				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W0000							
	This visit was for	r an annual fundamental	W0000				
	recertification an	d state licensure survey.					
	Dates of survey:	September 6 and 7, 2011					
		, ,					
	Surveyer: Vethy	Craig Madical Surveyor					
	Surveyor: Kathy Craig, Medical Surveyor						
	III						
	Facility Number: 009013						
	Provider Number: 15G675						
	AIMS Number:	100234550					
	The following deficiencies also reflect						
	state findings under 431 IAC 1.1.						
	Quality Review completed 9-20-11 by C. Neary,						
	Program Coordinator. The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.						
W0140							
		review and interview, the	W0140	What corrective action(s) wil			
	facility failed for 2 of 4 sampled clients			accomplished for these reside found to have been affected			
	(client #1 and #3	(client #1 and #3) by not ensuring they had an accurate accounting of their petty each funds		the deficient practice:Client #	· 1		
	had an accurate a			and #3 personal funds accou	•		
	cash funds.			have been reconciled and			
				demonstrate an accurate			
	Findings include:			accounting of their personal			
				fundsHow will we identify oth			
	D			residents having the potentia			
	Review on 9/6/11 at 4:25 PM of client			be affected by the same defi practice: All clients' personal	•		
	#3's August 2011 Petty Cash Ledger			funds accounts in this home			
	indicated as of 8/	/29/11, she should have		be examined and reconciled			
	had \$43.00 petty	cash. There were no		demonstrate an accurate			
	entries made on t	the ledger after 8/29/11.		accounting of their personal			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

009013

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G675		(X2) MULTIF A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 09/07/2011		
NAME OF PROVIDER OR SUPPLIER PASSAGES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 990 E HANNA ST COLUMBIA CITY, IN46725				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
	The counted petithis time was \$3 Interview on 9/6 Resident Managindicated she knowith \$5.00 cash account for their not in client #3's of reviewing and funds. Review on 9/6/1 #1's August 2011 indicated as of 8 had \$13.00. Their in the ledger after petty cash plus r \$27.00. Interview on 9/6 Resident Managindicated she knower in the amout #1 had won more previous Friday \$10.00 cash in heir Resident Managine record the mone.	ty cash plus receipts at 8.00, a minus of \$5.00. 6/11 at 4:30 PM with the er was conducted. She ew there was a receipt for spending money to missing \$5.00 but it was petty cash bag at the time d counting client #3's 1 at 4:40 PM of client Petty Cash Ledger /29/11, she should have ere were no entries made er 8/29/11. The counted eccipts at this time was 6/11 at 4:45 PM with the er was conducted. She ew client #1 would be ent of cash because client ey at Bingo on the and client #1 had put er petty cash bag. The er indicated she did not y client #1 had won at h she put in the petty cash			funds. What measures will be into place or what systemic changes will be made to ensith the deficient practices werecur: Clients' personal funds accounts will be reviewed or weekly basis to ensure a full complete accounting of clien personal funds. How will the corrective actions be monitorensure the deficient practice not recur: Clients' personal fraccounts will be reviewed or weekly basis by the group he manager to ensure a full and complete accounting of clien personal funds. What is the by which the systemic change will be completed: 10-1-11	ure ill not s and ts' red to will unds a ome ts' date	

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
		15G675	A. BUILDING			09/07/2011	
			B. WING GOOTH2611 STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER					HANNA ST		
PASSAGES INC					IBIA CITY, IN46725		
						77.0	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIATE		DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must provide or obtain proventive		1	IAG .			DATE
W0322	The facility must provide or obtain preventive and general medical care.						
	Based on record review and interview, the		W0322		Whatt correcttve actto(s) will be		10/01/2011
	facility failed for	1 of 4 sampled clients			accomplished fior tthese residentt	s	
	(client #3) by not	t ensuring she had a			fiound tto have been afiectted by t	ectted by tthe	
	mammogram.	S			deficientt practtce	eduled fior a	
					Clientt#3 is scheduled fior a		
	Findings include	-			mammogram on 10-4-11. Clientt# will have a mammogram annually		
	1 manigs merade	•			recommended by her physician	 	
D : 0/7/		11 at 9:00 AM of client			and/or guardian. An order fior tth		
					mammogram has been added tto	-	
		conducted. Client #3's			Clientt#3 Physicians orders and tto	,	
	_	cy Data Information"			tthe montthly medical scheduling		
	dated 3/23/11, indicated client #3 was over 80 years old. There was no evidence in client #3's record of her ever having a mammogram. Client #3's Physician's				fiorm as a reminder tto tthe sttafi	tto	
					make tthe appointtmentt when itt	is	
					due.		
					How will we identtfiy otther reside		
	Orders dated 7/1/	/11 did not indicate			having tthe pottenttal tto be afiect	ted	
	whether or not she was to have				by tthe same deficientt practice		
mammogram. Client #3's		lient #3's annual physical			All individuals who receive annual fiemale gynecological exams		
	exam dated 3/14/11 had no				including mammograms and pap		
	recommendation for her to have a				ttestts will have itt notted on tthei	r	
	mammogram. There was no evidence in				Physicians orders and on tthe		
	client #3's records of preventative				montthly scheduling fiorm as a		
					reminder tto tthe sttafi tto make tt	:he	
	guidelines.				appointtmentt when itt is due		
	0/5/41 1.05 73 5				Whatt measures will be putt intto		
	Interview on 9/7/11 at 1:25 PM with the facility nurse was conducted. The nurse indicated they did not have preventative				place or whatt systtemichanges w		
					be made tto ensure tthatt tthe def	ıcientt	
					practices to nott recur Mammograms and pan thests will	ho	
	-	ere dependent on the			Mammograms and pap ttestts will notted on Physicians orders and tt		
	doctor to make re	ecommendations. The			montthly scheduling fiorm as a		
nurse indicated there was nothing in client				reminder tto sttafi tto make tthe			
	#3's file to indicate if she has had a mammogram or not.				appointtmentt when itt is due		
					How will tthe corrective actions be	e	
					monittored tto ensure tthe deficie	ntt	
		1					

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G675	(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER PASSAGES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 990 E HANNA ST COLUMBIA CITY, IN46725				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
IAU	1.1-3-6(a)	LISC IDENTIF LING INFURMATION)	IAU	practtce will nott recur Healtth Services Coordinatt monittors scheduling florm and sends written reminde group home sttafi tto sched appointtmentts Whatt is tthe datte by whic systtemic changes will be co 10-1-11	or montthly rs tto lule h tthe	DATE	